Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTWEST FRWY SUITE 2200
HOUSTON TX 77027

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-06-3486-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Hermann Hospital System ('MHHS') submitted its UB92 and itemized statement reflecting ICD-9 code 806-01. Pursuant to TWCC Rule 134.401(c)(5) (trauma admit based upon ICD codes), reimbursement is based upon the hospital's fair and reasonable and usual and customary charges, which for dates of service 01/20/05 thru 02/14/05 is $395,872.75, and dates of service 02/15/05 thru 03/08/05 is $147,020.25. Dallas Fire Insurance Company issued an underpayment of $127,617.73 for dates of service 01/20/05 thru 02/14/05 and underpayment of $54,458.80 for dates of service 02/15/05 thru 03/08/05. However, this claim is an emergency admit and trauma. Therefore, additional reimbursement of $268,255.02 and $92,561.45 is due and owing to the hospital."

Amount in Dispute: $360,816.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With regard to the sole point of contention, Requestor maintains that Respondent did not provide reimburse it with usual and customary charges, which are the billed charges. This argument is wholly without merit. Respondent has made a valid and legal reimbursement, denial, or reduction of fees, under the Texas Department of Insurance, Division of Workers' Compensation (DWC) medical fee guidelines, rules and statutes. Specifically, Respondent used Division approved codes for its denial of reimbursement. (See attached Explanation of Benefits.) Based on these considerations, Respondent should not be responsible to reimburse Requestor additional fees."

Response Submitted by: Lewis & Backhaus, P.C., 14160 Dallas Parkway, Suite 400, Dallas, TX 75254

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2005 through February 14, 2005	Inpatient Services	$268,255.02	$0.00
February 15, 2005 through March 8, 2005	Inpatient Services	$92,561.45	$0.00
TOTAL		$360,816.47	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on January 20, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on February 1, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F-Fee guideline MAR reduction.
   - G-Unbundling.
   - J-Final Adjudication.
   - M-No MAR.
   - S01-Pursuant to Texas Labor Code 413.011 and other applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area.
   - S04-Separate reimbursement for this line item is denied. The clinical information and detail submitted on the procedures rendered, indicates that separate reimbursement for this line item would be inappropriate or has been included in the value of the procedure.
   - S06-Reimbursed at cost + 10% per guidelines.
   - S10-These services are exempt from the Acute Inpatient Hospital Fee guidelines.
   - TR1-Acute trauma care reimbursed to a standard of reasonableness for usual and customary.
   - VAL-A line item charge validation analysis was performed for this revenue cost center. Certain items were denied as being duplicate, unrelated, or unbundled charges.
   - S05-Stop loss threshold exceeded-recommended payment is at 75% of post-audit reasonable charges per Acute Hospital Inpatient Fee Guidelines.
   - W1-Workers Compensation State Fee Schedule Adjustment.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to

the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 806.01 for the disputed dates of service. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "Pursuant to TWCC Rule 134.401(c)(5) (trauma admit based upon ICD codes), reimbursement is based upon the hospital's fair and reasonable and usual and customary charges, which for dates of service 01/20/05 thru 02/14/05 is $395,872.75, and dates of service 02/15/05 thru 03/08/05 is $147,020.25."
   - The requestor did not discuss or explain how it determined that full reimbursement of the amount billed would yield a fair and reasonable reimbursement.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		1/12/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		1/12/2012
Signature	Health Care Management Executive Deputy Comm.	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.